STATE OF NEW JERSEY, ACCIDENT BLANK

REPORT EVERY ACCIDENT IMMEDIATELY

This report of accident is to be prepared in DUPLICATE. The original is to be sent to the Department of Labor, Bureau of Industrial Statistics, State House, Trenton, N. J. Carbon copy will not serve. The other copy is to be sent to

MARYLAND CASUALTY COMPANY

Newark Claim Division, Raymond Commerce Building, Newark 2, N. J.

Form "C" First notice of Accident. For use by insuring employers.

Newark Eagles Baseball Club
(Name of Employer)

71 Crawford St.
(Street Address)

Newark 2 N.J.
(City or Town)

Professional Baseball
(Business)

Date of Accident: 7 Number of Month; 13 Day of Month; 46 Year; 9 Hour A. M. / P. M.

Robery Harvey
(Name of Injured Employee)

9 Gardenier Pl.
(Street Address)

Montclair N.J.
(City or Town)

Ballplayer (3. Occupation) Negro (4. Nationality)

Date report received
(Leave this line blank)

1. State fully how accident occurred
Running into base, the ball thrown by the pitcher hit the runner

2. Exact part of person injured, with nature and extent of injury head

5. Sex male 6. Age 28 7. Married yes

8. Give name of machine or appliance involved

9. Indicate kind of work done on this machine

10. Name distinct part of machine causing injury

11. Was any guard protecting this portion of the machine?

12. Give probable period of disability

13. Was medical attention necessary? yes

14. Name and address of attending physician Dr. Darden 149 W. Kinney St. Newark N.J.

15. If sent to hospital, state name and location St Kinley Hosp. Trenton N.J.

16. Exact location of accident. If away from plant, give town, street and number Dunn Field Trenton N.J.

17. Were the wages fixed by the output?

18. If the wages were fixed by the hour, state RATE per hour

19. Give number of HOURS in ordinary day

20. Give number of DAYS in ordinary working week

21. State the amount of weekly WAGES $75.00

Date of preparing this blank July 20 19 46

Made out by

Before detaching, fill in on FORM "D" names, date of accident, and date seven days after.
If employee has resumed work at time of reporting, do not detach.

Newark Eagles Baseball Club
(Name of Employer)

71 Crawford St.
(Street Address)

Newark 2 N.J.
(City or Town)

Date of Accident: 7 Number of Month; 13 Day of Month; 46 Year

Robert Harvey
(Name of Injured Employee)

Date seven days after accident Must be mailed on or before

Report received
(Leave this blank)

30. Did employee lose any time? no

31. Date disability began

32. Is employee able to resume work?

33. If so, on what DATE?

34. State length of disability, weeks days

35. If not able to work give probable date of recovery

36. Has any permanent injury resulted?
If so, describe fully on back of form.

37. Has your insurance carrier arranged to file the compensation reports with the State for you?

Date of preparing this blank July 20 19 46

Made out by

If employee is still disabled at the time of preparing FORM "C", fill in names on this supplemental report, detach it and forward same, duly completed, on the SEVENTH DAY after the day of the accident, or on the day injured returns, if he is able to work before the expiration of seven days. If employee loses no time, or has returned to work at time of reporting, fill out FORM "D", but do not detach.

This report of accident is to be prepared in DUPLICATE. Mail the original (if detached) to the Department of Labor, Compensation Bureau, State House, Trenton, N. J. (carbon copy will not serve), and the duplicate copy to

MARYLAND CASUALTY COMPANY

Newark Claim Division, Raymond Commerce Building, Newark 2, N. J.

When in need of blanks, apply to your insurance carrier.

FORM "D". SUPPLEMENTAL REPORT. For use of insuring employers.

20511. PRINTED IN U.S.A.